

November 2021 Caseload Estimating Conference
Questions for the Executive Office of Health and Human Services,
the Department of Human Services, and the Department of Behavioral Healthcare,
Developmental Disabilities, and Hospitals

The members of the Caseload Estimating Conference request that the Executive Office of Health and Human Services, the Department of Human Services, and the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals provide written answers to the following questions in addition to the presentation of their estimates on Wednesday, October 27, 2021. Please submit the answers no later than close of business Friday, October 22, 2021 so that staff can have the opportunity to review the material prior to the meeting.

In addition to the caseload and expenditure estimates, the testimony should include background information supporting each estimate, including (but not limited to) caseload and unit cost trends and key assumptions underlying the projections, as has been provided in the past. The caseload information should also include expenses related to the State's COVID-19 PHE response.

Please include enrollment/utilization projections for both the Medical Assistance programs (including hospitals, nursing homes, pharmacy, in addition to the capitated programs) and the Private Community Developmental Disability programs (including Residential Habilitation, Day Program, Employment, Transportation, Case Management and Other Support Services, L9 Supplemental Funding, and Non-Medicaid Funding). Please provide a separate copy of any information that is requested as an Excel workbook.

MEDICAL ASSISTANCE

All tables provided by the conferees for EOHHS to populate are included in a separate Excel workbook (emailed as an excel attachment along with the questions). Tab 4 – Rate Changes and EOHHS' model will be provided before the testimony. References to each tab are included throughout this document.

- 1) Please provide, where possible, excel spreadsheets/tables with details/explanation for your narrative testimony related to expenditures, eligibility, growth factors, rate changes and methodology for projections. Please include notes/comments on any related adjustments or factors that are relevant to the estimate.

See testimony.

- 2) Please update "Tab 1" of the attached file (or provide a similar file) showing average caseload and average capitation rates for all managed care product lines to reflect the Executive Office's estimates for FY 2022 and FY 2023. Please update FY 2021 final and FY 2022 enacted information as necessary.

See attached.

- 3) Please provide a list of any state only medical assistance payments to be made in FY 2022 and FY 2023 and the reason why the payments are being made. Also provide backup documentation that shows the services provided and payment(s) requested.

This answer is unchanged from May.

There remains one non-material, recurring state-only expense:

Rite Start Program. In FY 2020 there were approx. \$170,000 in expenditures for this program. In FY 2021 and FY 2022 on the Managed Care – State Only account EOHHS includes \$200,000 for this program.

The program is described at <http://webserver.rilin.state.ri.us/Statutes/TITLE42/42-12.3/42-12.3-3.HTM> and covers extended family planning benefits for women who do not have qualified immigrant status for Medicaid.

Additional State-only Expenses:

Settlement for certain NICU claims based on hospital reported discharge DRG

EOHHS' MMIS vendor utilizes 3M's APR-DRG software to reimburse on an "admission" DRG. The settlements are to compensate for diagnoses present on discharge not accounted for in claims payment.

\$1 million GR is earmarked as a potential liability in FY 2022 and FY 2023. In FY 2021 total NICU state-only payments to Women & Infants totaled \$609,490.

Nursing Home Contingency Payments:

EOHHS issued payments in July 2020 for prior period activity. No new interim payments have been made since July.

COVID-19 Impact and Expenses

- 1) Please provide an updated summary of how the COVID-19 pandemic has impacted, and is projected to impact, enrollment, rates, and expenditures across all programs (managed care and fee-for-service), how that is factored into your caseload estimates, and how projections have changed since the budget was enacted.

- The termination moratorium is discussed in **Question 4** below.
- The impact of the COVID-19 pandemic on EOHHS' caseload is presented in the **Major Developments** section of our testimony:
 - **COVID-19 Vaccine Administration.** The EOHHS budget includes nearly 600,000 doses administered through end of the current fiscal year and another 270,00 doses to be administered in FY 2023 at a cost of \$24.7 million and \$11.2 million, respectively.
 - **Enhanced FMAP for Home and Community Based Services.** EOHHS has identified an estimated \$60.6 million in new federal match that will free up an equal amount new GR that will be deposited into a Restricted account to be used as state share available to reinvest in Medicaid HCBS as approved by CMS in the State's spending plan. As this funding is spent, additional federal match will be drawn down per federal regulations, generating ~\$133.7 million for HCBS initiatives through March 31, 2024.
 - **Enhanced FMAP related to the Public Health Emergency (PHE).** EOHHS testimony assumes the PHE and enhanced 6.2% FMAP ends on December 31, 2021. **Table II-12** provides conferees with a high-level estimate of the financial impact of a one quarter extension of the PHE through March 2022.
 - **Caseload trends during the COVID-19 pandemic.** Of note, Rhode Island's recent experience during the public health emergency has been consistent with regional trends per CMS data. Nonetheless, the increase to Rhode Island's caseload has been significant. This section also details anticipated terminations. Overall, EOHHS forecast assumes that during the second half of the FY 2022 for those population groups that experienced growth, aggregate caseload will decline by one-third of the growth experienced through the entire PHE period (i.e. between March 2020 and December 2021)
- **FFS utilization.** As vaccinations increase and people who have been delaying care begin to receive it, outpatient, professional, nursing facility/LTSS, and dental services might increase. Given this uncertainty, EOHHS projections took the following approach to determine baseline spending:
 - FY 2022. For most FFS items except Nursing Facility/Hospice spend, the estimate takes the highest monthly average of either the pre-COVID (October 2019 through March 2020) or current trends (October 2020 to June 2021). Applicable rate increases are applied when necessary. For Nursing Facility/Hospice the methodology was:
 - For the first quarter, the estimate is based on March through June 2021 monthly average spend, which is the most recent reliable data available to EOHHS.
 - The second quarter of FY 2022 is the average of the above-mentioned trend, and the below trend, adjusted for rate increases.
 - The last six months of FY 2022 are projected to be back at pre-COVID levels (October 2019 to March 2020), inflated for applicable rate adjustments (An additional 2.4% beginning 10/1/2020 and 2.2% beginning on 10/1/2021)

- For all FFS, the baseline was established using claims data, adjusted for IBNR, and annualized. Once completed, FY 22 initiatives were layered in to determine final FY spend.
- *FY 2023.* Except for nursing facilities, the FY 2023 estimate takes the selected FY 22 monthly average; annualizes the monthly average spend; and adjusts for the IBNR
 - *Nursing facilities and hospice.* The FY 2023 estimate takes the estimate takes the monthly average from October 2019 to March 2020 (pre-COVID) and inflates by all applicable rate increases (2.4% on 10/1/2020, 2.2% on 10/1/2021, and 2.7% projected for 10/1/22).

- **Managed Care Utilization**

- The actuarially certified rates for FY 2022 utilize experience from FY 2019. In terms of actuarial standards this is the longest lag allowed for purposes of establishing credible baselines. In typical years, Rhode Island would be leveraging its FY 2020 experience to set its FY 2022 rates. However, due to COVID-19 utilization patterns that period is not considered credible experience for purposes of forecasting future utilization. The use of FY 2019 as a baseline is not unique to Rhode Island.
- Adjustments were subsequently made to account for potential changes in general acuity between FY 2019 and anticipated for FY 2022 due to continued enrollment growth as well as subsequent termination schedule in the latter part of the fiscal year.
- The health plans do not have credible risk share reporting for FY 2022 and with the assumption that the rates are credible and sufficient, EOHHS has not forecasted any risk share liabilities.

The significant level of anticipated termination activity in the later half of FY 2022 continuing into the first half of FY 2023 contribute to the higher-than-usual price factor of 5.0% applied to all the FY 2023 premiums. It is likely that the members who lose eligibility have lower acuity (i.e., lower health care expenditures) and this would raise the composite PMPM of those remaining enrolled effectively raising the annual price trend.

- a. Please delineate COVID-19 expenses relevant to the Medicaid program that were allocated to the Coronavirus Relief Fund (CRF), including funds that may be encumbered or planned but have not yet been spent. [Note: these expenses may be incurred in other programs but impact Medicaid providers, such as HAPP.] Please provide additional details for the LTSS Resiliency Fund and HAPP, including the amounts paid to each provider.

Please see spreadsheet below from the DOA that details all CRF expenditures in the health agencies through September 30, 2021.



EOHHS CRF Report
Summary 2021-09-30

Please see spreadsheet below from DOA that details all HAPP expenditures through September 30, 2021.



HAPP Spending.xlsx

Please see spreadsheet below which details expenditures from the LTSS Resiliency Fund



LTSS

Spending-caseload up

- b. Please identify any specific program changes funded by the LTSS Resiliency Fund that have affected the Medicaid program. For example, any programs that expand capacity, such as shared living.

See the list of programs in (1)(a)(iii).

A larger goal of the LTSS Resiliency Fund and associated programs has been to re-orient the delivery of care in nursing facilities and expand home and community-based service (HCBS) options to enable Rhode Islanders to remain in the community, through home-based workforce incentives, training and support. Of the 14 programs funded by the Resiliency Fund, 12 have been for HCBS services, and \$6.6 million has been invested through these initiatives. EOHHS believes that these investments and any observed impact are included in our SFY 22 and SFY 23 estimates. It is unclear to EOHHS how much of the increased utilization is due to COVID or to the investments, or a combination of both. EOHHS's estimate are conservative—increasing HCBS spend in both years to capture increased utilization that is a current trend for most HCBS services, and budgeting nursing facility spend with anticipated LTSS package savings.

- c. Please provide data on all program metrics and outcomes assessed to date.

Please see spreadsheet below. Note that the Workforce Stabilization Program audit report was included in our April testimony; therefore, it is not included here again.



Resiliency Program
Reporting 2021-101

Included below is a copy of the Office of Internal Audit's findings related to the Workforce Stabilization Loan Program.



Workforce
Stabilization Audit-

Note that since the publication of the audit report, EOHHS has participated in several appeal hearings regarding the use of loan funds. As of 10/20/2021, the State expended \$16.3 million in loan funding, of which, \$13.4 million was distributed to workers, and \$2.8 million is in the process of being recouped.

- 2) Please identify any programs available through the American Rescue Plan not accounted for in the FY 2022 Enacted Budget.
- a. Regarding the temporary 10 percent FMAP increase for home and community-based services (April 1, 2021 through March 31, 2022), please provide information on the submitted plan and an update on the timeline for expected CMS response/approval. How will this be accounted for in the estimates?
- See testimony. Additionally, all communications with CMS, including spending plan updates, are online here:*
- <https://eohhs.ri.gov/initiatives/american-rescue-plan-act/home-and-community-based-services-hcbs-enhancement>*
- 3) Please provide an updated impact of the current delay in terminations associated with the enhanced FMAP compared to the enacted budget including any updated guidance regarding terminations provided by CMS.

- a. How many individuals are in the pool of potential terminations that are on hold?

By suppressing nearly all terminations, the Medicaid program has shielded just over 38,000 members from being terminated through early October 2021. Approximately 8,000 have since regained eligibility for a net 30,000 members who remain on the Medicaid program who would be subject to potential termination.

- b. What is the timeline for terminating these cases once the public health emergency ends?

EOHHS interprets this question to mean, "what is the timeline for redetermining eligibility for these cases," as not all will be terminated. Once the PHE ends, EOHHS and DHS will have to process renewals for all individuals who have had their renewal dates extended forward. CMS is now allowing states 12 months to complete those renewals once the PHE ends. EOHHS' projections assume that full 12 months is needed; EOHHS is currently doing renewals of MAGI individuals and planning to begin renewals for non-MAGI groups in order to process as much work in advance of the PHE's end.

- c. How many individuals have voluntarily terminated Medicaid enrollment?

Terminations have been completed for being deceased, changing residency or withdrawal. See below.

- d. Please provide a monthly breakdown of activity for these individuals, since the start of the pandemic, including how many are added to the pool each month or voluntarily terminated.

Term Reason	3/31/20	4/30/20	5/31/20	6/30/20	7/31/20	8/31/20	9/30/20	10/31/20	11/30/20	12/31/20	1/31/21	2/28/21	3/31/21	4/30/21	5/31/21	6/30/21	7/31/21	8/31/21	9/30/21	10/31/21	Grand Total
Deceased	270	464	563	328	229	226	240	264	287	386	308	202	92	14	220	173	158	147	86	37	4694
Residency	23	37	64	87	158	97	111	99	83	123	107	109	175	203	209	206	235	256	253	208	2843
Withdrawal	69	208	295	418	425	432	532	525	529	504	380	548	664	502	498	504	495	608	668	606	9410
Grand Total	362	709	922	833	812	755	883	888	899	1013	795	859	931	719	927	883	888	1011	1007	851	16947

- 4) Please separately identify the general revenue savings from the enhanced FMAP rate and the increased expenses from a delay in redeterminations for FY 2022. Note if there is an impact from the redetermination delay in FY 2023.

Medicaid eligibility has increased by nearly 50,000 members over the last 20 months of the pandemic. Prior to pandemic, enrollment was trending downward. It is quite possible that EOHHS' enrollment would be even lower today that it was in February 2020. Or it could have experienced some modest growth; that is, not all 50,000 members are tied directly to the moratorium on terminations.

In general, the cost associated with the additional member months of enrollment due to the moratorium on termination activity was reflected in our All Funds expenditures in FY 2021 and will continue to be felt in FY 2022 and FY 2023 only so far as members who could otherwise have been terminated are retained only because of the current moratorium.

Overall, the gross GR savings from the 6.20% increase to Rhode Island's Regular FMAP exceed the marginal increase in state spending associated with the moratorium on terminations (and therefore continued payment for members who would otherwise have lost eligibility).

For FY 2022, EOHHS forecast assumes an additional \$59.6 million GR from the enhanced FMAP through December 31, 2021. No enhanced FMAP is assumed for FY 2023. EOHHS' CEC model allocates these to the appropriate COVID-19 Line Sequences.

Additional GR savings are attributed to DCYF, BHDDH, and DHS Medicaid expenditures that are not reflected herein.

*Please refer to section L of **Major Developments** for additional discussion.*

A supplemental Excel workbook is being prepared by EOHHS to help the conferees and their offices amend their caseload assumptions and splits by funding source for if/when additional information on the Public Health Emergency is released after October 20, 2021 (the date when EOHHS completed its initial preparation for the testimony).

- 5) During the public health emergency, EOHHS applied for, and on March 17, 2021 received, federal approval that allows the state to extend certain program changes that were made available to respond to the

COVID-19 public health emergency for another six months after the emergency ends. Please update the information provided during the May 2021 Conference on the status of these changes.

This answer has not changed since last testimony.

Waiver authority	Implemented Non-DD	Implemented DD	continue Non-DD	continue DD	Cost
Did not implement					
Suspend HCBS person-centered service plan reviews for 6 months	No, because service planning continued via telephonic means.	No	No	N/A	No
Temporarily exceed HCBS service limitations	No	No	N/A	N/A	N/A
Temporarily expand HCBS setting(s) where services may be provided	No	No	N/A	N/A	N/A
Add medical supplies, equipment, and appliances for HCBS	No	No	N/A	N/A	N/A
Authorize HCBS case management entities to provide direct services; current safeguards authorized in the approved waiver will apply to these entities	No	No	N/A	N/A	N/A
Modify HCBS requirements for institutional level of care determinations	Yes	No	No	N/A	No
Implemented, no cost, will not continue					
Temporarily modify licensure or other requirements for HCBS settings where waiver services are furnished	No	Yes, 3/2020 gave the Residential Provider Agencies funding to implement Day Programming in the group home; increased from 60% Community Based Day funding and 40% Center Based Day funding to 100% Community Based Day funding and did not require that services happen within the community.	N/A	No	No
Waive requirement to allow visitors at HCBS settings	Yes	Yes	No	No	No
Implemented, plan to continue					
Allow HCBS person-centered service plan process to be conducted via telehealth	Always allowed, and continued to allow	Yes	Yes	Yes	Not additive
Temporarily permit payment for HCBS services rendered by family caregivers or legally responsible individuals	This was implemented to 2 families in 4/2020; managed care was not implementing, and the delivery systems need to be equal.	Yes	No	Yes	Not additive (BHDDH impact)

Add an electronic method of service delivery for HCBS	Yes	Yes	Yes	Yes	Not additive
Permit three 30 consecutive day periods for retainer payments	No	Retainer payments were paid to providers in April and May 2020.	N/A	No plans to pay out the third	Yes, to BHDDH
Allow for an extension of reassessments and reevaluations for HCBS	Yes, March 2020	Yes, March 2020	Yes	Yes	Not additive
Extend HCBS level of care authorizations	Yes, March 2020	No	No	N/A	Not additive

- 6) Please provide an update to how enrollment assumptions reflect the end of the Pandemic Unemployment Assistance Program.

There is not an explicit adjustment for the end of the PUAP. As discussed in prior caseload testimonies, there is not a clear link between unemployment and Medicaid enrollment in any recession and that relationship is more tenuous in this pandemic where the PHE has prohibited most terminations.

The Pandemic Unemployment Assistance Program was a separate program for people not typically eligible for Unemployment Insurance (independent contractors, small business owners, and people out of work due to COVID specifically). PUAP was excluded as income in Medicaid eligibility determinations, though it could have been included if people reported it as standard UI income. If it were included as income in eligibility determinations, its end would lead to more people with lower income, all else equal. However, all else was not equal as labor market conditions have concurrently changed.

The weekly unemployment income boost (not PUAP, but Federal Pandemic Unemployment Compensation) was excluded for Medicaid eligibility.

FY 2021 Closing

- 1) Please provide a FY 2021 closing analysis by program (in the same format that has been used for prior November testimony) with a separate column identifying any variance to the preliminary closing.

- a. Include an explanation of the impact of accruals and any prior period adjustments on the program's final closing position.

*See general analysis in **Major Developments** of testimony with supporting Excel Workbook*

- b. Include the total UPL payment made by funding source.

*EOHHS reclassifies UPL payments after the close of each quarter based on the proportion of FFS activity that is for Expansion-eligible members. These dollars are transferred from **Hospital – Regular** to **Expansion** and summarized below for FY 2022:*

Funding Source	Budget Line	Line Sequence	Source	Amount
E1	Expansion	2004108.01	GR	\$198,122
		2010105.02	FF	\$1,783,091
10	Hospitals - Regular	2002103.01	GR	\$2,374,948
		2008103.02	FF	\$3,196,368
		4628416.02	FF	\$368,254
				\$7,920,783

For FY 2022 and FY 2023, EOHHS is assuming that 23% of both Inpatient and Outpatient UPL payments will be eligible for Expansion.

	FY 2021	FY 2022 Est.	FY 2023 Est.
Regular FMAP	\$5939,571	\$22,666,650	\$22,666,650
Expansion FMAP	\$1,981,212	\$6,770,558	\$6,770,558
Total	\$7,920,783	\$29,437,208	\$29,437,208
Overall GR Cost	\$2,573,070	\$10,246,915	\$11,060,648

The entire FY 2021 and half of the FY 2022 payments made using regular FMAP will be eligible for the additional 6.20% giving EOHHS some additional GR relief in the current fiscal year.

- c. Identify any adjustments made between programs for non-emergency transportation services compared to the FY 2021 final budget.

*All non-emergency transportation service premiums for EOHHS' Aged, Blind, and Disabled members are initially charged to **Other Services** line sequences. Subsequently, EOHHS prepares journal entries to transfer the cost of enrollment for members enrolled in **Rhody Health Options** and **Rhody Health Partners** to their respective budget lines.*

These necessary adjustments were all captured during the fiscal year and are summarized below:

Budget Line	Line Sequence	Source	Amount
Other Services	2004103.01	GR	\$2,727,119
	2010102.02	FF	\$3,714,677
	2400114.02	FF	\$425,790
			\$6,867,586
Rhody Health Options	2006103.01	GR	\$1,259,321
	2012104.02	FF	\$1,715,353
	4628414.02	FF	\$196,620
			\$3,171,294
Rhody Health Partners	2006101.01	GR	\$750,551
	2012101.02	FF	\$1,022,345
	4628415.02	FF	\$117,185
			\$1,890,081
Grand Total			\$11,928,961
Overall GR Cost			\$4,736,991

Note. The allocate of expenditures in EOHHS' CEC model modestly differ from the above amounts as the model uses the current distribution by age to proxy a PMPM for the entire fiscal year: e.g., FY 2021 incurred amount for Other Services is currently being reflected as \$6,883,795 versus \$6,867,586 posted to RIFANS.

- 2) Please include a column for FY 2021 closing figures in the summary tables within each section of your testimony.

Each summary table includes the FY 2021 Preliminary Fiscal Close.

Please note that an attempt was made to reflect incurred data above the line with the necessary prior-period activity reflected as below-the-line adjustments to balance to the preliminarily close in RIFANS.

FY 2022 Budget

- 1) Please include a status update on FY 2022 budget initiatives as outlined in "Tab 2". Please include information regarding regulatory changes and amendment submissions/approvals, where appropriate.

See Attachment 2.

Long Term Care Offline Payments & Reconciliation

- 1) Please update the information in "Tabs 3a-3d" for advances made to nursing facilities, assisted living facilities, and home care and hospice providers by month, payment, and provider in FY 2021 and FY 2022 to date. What is currently assumed for FY 2023?

Please see completed 3a, 3b, 3c, and 3d tab in the 2021 NOV CEC Questions – EOHHS Tables workbook sent to EOHHS for advances and recoupments through September 30, 2021.

Upcoming recoupment activities in SFY 23 include continued recoupment from nursing facilities. This month, EOHHS began Assisted Living recoupments. In SFY 23, EOHHS anticipates beginning hospice and homecare recoupments. Essentially, EOHHS is assuming no additional interim payments will be made or that if they are, they are recouped in full and paid as claims.

- 2) What is the current backlog resulting from any eligibility processing issues?

As of 10/19/21:

- 291 Open Applications-pending processing
 - 38 of which are overdue (greater than 90 days), pending State work
- 317 Pending state in the pipeline for eligibility determination (pending completion and functional assessments)
 - 70 of which are overdue, but includes those with financial/legal complexities

- 3) Please provide a separate list of providers to whom advances have been made again following reconciliation/recoupment of a previous payment(s).

- i. Hospice. EOHHS has only recouped funding from one of five providers. No interim payments were made to this provider after recoupment
- ii. Assisted Living. EOHHS has only recouped funding from one of 24 providers. No interim payments were made to this provider after recoupment. Assisted living recoupment has begun as of 10/15/2021
- iii. Nursing Facilities. 39 facilities no longer have an outstanding balance owed (they may have denied claims the state cannot recoup). EOHHS has not then reissued new advances to those providers.
- iv. HCBS. None of the providers who received advances have been fully recouped.

- 4) Please provide an update on the timely eligibility approval process and an update on any current backlog of applications. How many are past the 90 days as of October 1, 2021?

As of 10/19/21:

291 open eligibility Applications-pending processing actions

- 38 of which are overdue (greater than 90 days) and pending State action

317 LTSS applications are pending State action in the pipeline (Functional Assessments, etc)

- 70 of which are overdue (greater than 90 days) and pending State action or have financial / legal complexities.

New Programs

- 1) Please identify any new programs that were not part of the FY 2022 Enacted Budget but have been approved through the waiver or other programs that will be implemented in either FY 2022 or FY 2023. What are the costs per initiative and by program?

All new waiver programs being implemented were included in the Enacted budget.

- 2) Please identify if the new programs are considered pilot programs and what the out-year costs will be if fully implemented.

There are no current new waiver authorities being piloted in the Medical Assistance estimates.

Health System Transformation Project – Accountable Entities

- 1) The FY 2022 Enacted Budget includes \$25.0 million in the Medical Assistance program for the accountable entities and managed care plans. Please update the list of the organizations involved in the project, how many individuals are enrolled in each organization, and if those individuals are also enrolled in managed care plans. Please also provide a description of the any direct benefits provided by them.
- a. For FY 2021, what incentive payments were made to each entity and which milestones were met by each one?

The Health System Transformation Project (HSTP) funds in the Medical Assistance program support the Accountable Entity (AE) and Managed Care Organization (MCO) incentive program. The incentive program enables AEs and MCOs to develop the infrastructure and capacity to improve quality of care, reduce total cost of care, and improve population health. AEs earn these funds by achieving programmatic milestones, such as the execution of a downside risk contract or collection of Race/Ethnicity/Language data, or by demonstrating performance improvement on a set of standard utilization measures and individualized project performance measures. MCOs also receive a smaller portion of incentive funds to support the implementation of the AE program through their contracts with AEs; MCOs also provide technical assistance, data analytics, and other tools to support their contracted AEs in succeeding under their value-based payment arrangements.

The direct Medicaid covered benefits provided under the AE program are the same benefits covered for all managed care enrollees. AEs spend the incentive funds they receive to develop capacity and test interventions and care models in order to improve the integration of medical, behavioral health, and social services for their members, reduce utilization of low value care, and succeed under a Total Cost of Care (TCOC) model. Once incentive funds are earned, AEs have broad discretion in how funds are spent to advance their unique AE programming. That said, information gathered by EOHHS indicates that AEs spend incentive funds predominantly on personnel expenditures to support care management, behavioral health integration, and social determinants of health screening and referral services. Incentive funds also support AEs' contractual arrangements with community-based organizations and investments in health information technology.

The following tables include a list of the participating AEs and MCOs, their attributed members, and the total FY 2021 incentive payments received to date. All attributed AE members are enrolled in managed care as the AE program is managed through EOHHS' contracts with the MCOs; there are a total of 190,995 members attributed to AEs as of August 2021.

Accountable Entity	Attributed Members (August 2021)	FY 2021 Total Incentive Payment Received
Blackstone Valley Community Health Center (BVCHC)	13,707	\$1,094,182.43
Coastal Medical	13,859	\$1,084,105.83
Integra	50,577	\$4,407,568.20
Integrated Healthcare Partners (IHP)	29,092	\$3,941,776.43
Prospect Medical Services	20,817	\$1,424,953.66
Providence Community Health Center (PCHC)	52,547	\$4,439,905.58
Thundermist Health Center (New AE in SFY22)	24,103	NA (Participated under IHP in FY 2021)
Total	190,995	\$16,392,492.13

Managed Care Organization	Members Attributed to AEs (August 2021)	FY 2021 Total Incentive Payment Received
Neighborhood Health Plan of RI	120,827	\$2,065,391.27
United HealthCare	70,168	\$1,042,210.83
Total	190,995	\$3,107,602.10

These payments reflect achievement of defined program year three milestones, which include fixed milestones defined by EOHHS, performance improvement on a set of outcome measures, and achievement of project-based metrics, which are unique to each AE. All AEs have met their fixed milestones: 1) Submission of a pandemic safety and preparedness plan; 2) Execution of a qualified APM contract; and 3) Execution of an agreement with Social Service Organization, BH, and/or SUD Provider reflective of patient panel needs. All AEs have achieved the majority of funds related to outcome measurement (which was awarded for the development and implementation of a comprehensive performance improvement plan rather than performance on utilization-based measures in light of COVID-19 related disruptions in care). AEs vary in their achievement of the last milestone, their project-based measures, as they are in different phases of implementing their unique array of programming. The table below includes examples of project-based measures achieved by each AE.

For a more detailed description of each milestone and the associated allocation, refer to pages 6 and 7 of the [program year three incentive program requirements document](#). AEs can earn their outstanding incentive payments for FY 2021 (program year three) up to a year later (these remaining program year three funds were accrued to FY 2021). Note, \$2.1 million in payments were made in early FY 2021 that were attributed to program year two and are not included in the table above.

AE	Project	Measures
Integra	PY3 Project #2: Disease Management, Wellness, and Engagement	<p>Healthy Homes Pilot Engagement: Tracked the extent to which families enrolled in the Healthy Homes asthma program remain engaged over the course of their involvement with the clinical team.</p> <p>Number of Virtual or Physical Mindfulness Workshops Offered: Tracked success in rolling out the behavioral wellness initiative by counting the number of workshops sponsored by Integra and communicated to its members either directly or through broad based communication.</p>
IHP	PY3 Project #2: Complex Care Management	<p>Increase Access to Primary Care for IHP Homebound Individuals: Participating IHP providers added visits to their calendar through primary care or care manager services to meet the unique needs of IHP attributed homebound members. Services were provided in the patient's home or through telemedicine.</p> <p>Increase Engagement with Emergency Department Utilizers: Provided education in primary care aftercare post-ED discharge. Included education on cost effective treatment options and managing non-urgent symptoms outside of the ED.</p>
Coastal Medical	PY3 Project #1: Patient Engagement	<p>Current and Attributed Coastal AE Patients Actively Engaged with Primary Care Team: Quantified and increased the number of AE patients actively engaged with their PCP and care team. Actively engaged patients were defined as those who completed at least one encounter with their PCP.</p> <p>Outreach to AE Auto-Assigned Patients Not Currently Engaged: Reached out to 100% of patients who were auto-assigned to a Coastal PCP and who had not previously been engaged with a Coastal provider through a variety of communication methods.</p>
PCHC	PY3 Project #1: Behavioral Health Transitions of Care	<p>Outreach: Outreach made to over 900 BH-Transitions of Care candidate patients with 7 days of known ER, Inpatient, or Integrated Health Home (IHH) discharge.</p> <p>SDoH Assessment: Assessed and referred patients who agree to receive help and have one of the following diagnoses: depression; bipolar; schizophrenia; and/or IHH status known to PCHC.</p>
Prospect	PY3 Project #1: Care Management	<p>Expand ED Frequent Utilizer Engagement Program: Expanded a pilot program to engage frequent ED utilizers to a total of 5 practices.</p> <p>Increase Engagement with Identified ED Frequent Utilizers: Tracked engagement with AE members who qualify for their ED Frequent Utilizer Engagement Program, which seeks to engage high utilizers within 3 business days of an ED discharge (partially completed).</p>
BVCHC	PY3 Project #1: Expansion of Care Delivery	<p>Increase Open Access: Increased the percentage of unique patients seen during their open access hours (outside normal 8:00am – 5:00pm operating hours).</p> <p>Increase MAT Capacity: Increased the total number of patients engaged with BVCHC on medication assisted treatment (MAT) for substance use disorder.</p>

It is anticipated that the projects and population health management strategies implemented by AEs and supported primarily through incentive funds will yield some cost savings and/or improvements in quality outcomes. Due to claims lag, quality and cost outcomes for SFY21 have not yet been calculated. EOHHS plans to share performance data publicly with the AE Advisory Committee when those results are available in the coming months. That said, EOHHS is happy to share performance data from the AE program to date:

- In Program Year 1 (SFY 2019) 3 AEs were able to achieve savings versus their total cost of care (TCOC) benchmarks, totaling **\$6.06M**
 - Quality scores were largely awarded on a pay-for-reporting basis
 - In Program Year 2 (SFY 2020) 5 AEs achieved savings totaling **\$14.62M**
 - Quality scores were largely awarded on a pay-for-reporting basis
 - While COVID-19 impacted healthcare utilization during calendar year 2020, AEs observed reductions in ED visits among people with mental illness and potentially avoidable ED visits between 2019-2020, with mixed results on all-cause readmissions.
- 2) Please provide an updated plan for including the accountable entities as part of the overall managed care system. How will the funding be spent through the accountable entities in coordination with the managed care plans?

The AEs are already an integral component of the overall managed care system. MCOs contract with AEs, who provide direct healthcare services and coordinate members' care across medical, behavioral health, and social services. Both the MCOs and AEs have financial incentives to partner and coordinate to establish the best possible care delivery for their population. AEs and MCOs are expected (through contractual terms and program requirements) to work together to ensure care coordination is streamlined, lines of accountability are clear, and services are not being duplicated. EOHHS' vision as AEs and MCOs assume increasing levels of financial risk is that AEs, in partnership with MCOs, have built the necessary infrastructure and gained sufficient experience in managing costs and improving quality outcomes to be able to earn shared savings and sustain the staffing and infrastructure needed to effectively manage an AE. MCOs will be increasingly expected to provide resources, such as data, technical assistance, and care management funds in order to support AEs in managing costs and improving care quality and health outcomes.

HSTP Background - Rhode Island Medicaid's 1115 Waiver enabled EOHHS to establish a Designated State Health Program, which grants authority for CMS to match spending on health professional education at the state's public higher education institutions and restricts funding uses to the establishment of value-based payment models through the AE provider networks. Through the Medicaid 1115 Waiver and federal funding participation, the total available HSTP spend is approximately \$240 million. Transitioning the Medicaid program from fee-for-service to a value-based payment model is necessary to continue to improve quality and reduce cost. Value-based payment models reward quality, population health outcomes and cost efficiency and enable innovative and more holistic models of care delivery that encourage meaningful partnerships between payers and providers.

HSTP continues to work to achieve these goals through the AEs that are integrated provider networks responsible for the TCOC as well as the healthcare quality and clinical outcomes of an attributed population; through the development of a value-based framework in Long Term Services and Supports (LTSS); with investments in workforce transformation through the three institutes of higher education and the Rhode Island Department of Labor and Training; and through centralized infrastructure investments that seek to address and support interventions aimed at Behavioral Health and Social Determinants of Health (SDOH). Through FY 2021, EOHHS has deployed over \$10 million in funds outside of the Medical Assistance program on workforce transformation and supported projects targeting SDOHs.

Total Cost of Care - Participation in the program requires that our MCO partners enter TCOC contracts with AEs that set benchmarks for performance. In the first three years of the program, AEs were in shared savings-only TCOC contracts with the MCOs and were further insulated from financial losses through the incentive funds that supported the newly formed networks, if programmatic and outcome-based milestones were met.

EOHHS intended to require that eligible AEs enter TCOC contracts that include both shared savings and downside risk starting in program year three (FY 2021). However, due to the COVID-19 pandemic and the uncertainty regarding impacts on utilization and provider financial stability, EOHHS allowed all AEs to continue in upside-only contracts for program year three. To earn shared savings distributions, AEs must achieve quality benchmarks; quality performance as measured by an overall quality score is factored into shared savings calculations as a multiplier. In program year three, EOHHS also intended to move from a largely pay-for-reporting quality paradigm (where AEs earned points toward their overall quality score by reporting on quality) to pay-for-performance (where certain levels of performance and/or improvement are required to earn quality score points). However, again due to the COVID-19 pandemic, EOHHS chose to defer that transition. In the current program year (four), EOHHS identified a set of quality measures that will be pay-for-performance and used careful methodologies to adjust quality targets to account for ongoing pandemic-related challenges.

- a. **Assumption of Downside Risk for Program Year 4 (FY22) and Beyond** – Beginning in program year four (FY 2022), non-Federally Qualified Health Centers (FQHC)-based AEs were required to enter TCOC contracts that include both shared savings and downside risk sharing with a downside risk exposure cap of 1% of TCOC or 3% of provider revenue (whichever is smaller); this will increase to 2% of TCOC or 6% of provider revenue at risk in program year five. AEs in risk-based contracts will receive at least 60% of the Shared Savings Pool and will be responsible for at least 30% of Shared Losses (increases to 40% in program year five). Failure to achieve quality benchmarks will reduce the amounts of shared savings that the AEs may earn, and conversely, high quality performance will partially buffer AEs from shared losses.

- b. **Downside Risk for FQHC-Based AEs** - Beginning in program year five (FY23), EOHHS plans to offer Federally Qualified Health Centers (FQHC)-based AEs the option to participate in a downside risk contract, assuming risk consistent with the program year 4 standards noted above. FQHC-based AEs will not be required to take this downside risk option; they may remain in shared savings-only contracts if they progress towards value-based care and alternative payments through an EOHHS-approved project designed to generate healthcare cost savings.

Incentive Program – Moving Towards Paying for Outcomes - The incentive program funds in the Medical Assistance program are designed to support ongoing investments in staffing and infrastructure (e.g., IT platforms for risk segmentation and population health management) that are not currently supported in a fee-for-service reimbursement model, but that can add value in terms of reducing the healthcare cost experience and improving quality of care for an attributed population. Through FY 2021, EOHHS has distributed nearly \$62 million in HSTP incentive payments directly to AEs and MCOs. Program year six (FY 2024) is the last year of budgeted AE and MCO incentive program funding. EOHHS has begun development of a sustainability plan to ensure the continuation of effective strategies that yield cost savings in a value-based care environment when incentive funds are no longer available.

In program year three, EOHHS had planned to tie incentive funds to performance on outcome metrics, rather than to development of plans to address outcome metrics. EOHHS delayed the change to a pay-for-performance model for these incentive funds due to the uncertain impact of COVID-19. Now, in program year four (FY 2022), EOHHS has tied 35% of incentive funds to achievement of certain levels of performance on outcome measures (Plan All-Cause Readmissions; Potentially Preventable Emergency Department Visits; and Emergency Department Visits for Members with Mental Illness).

AEs can earn the remaining 65% of their incentive funds through:

- Executing an agreement to take on “downside” risk (non-FQHC-based AEs) or executing an agreement to implement a return on investment project (FQHC-based AEs);
- Reporting three quality measures with stratifications for race, ethnicity, language, and disability status to support evaluation of efforts to reduce disparities; and
- Achieving project-based performance measures, including measures for at least two projects on behavioral health integration and addressing social determinants of health respectively.
- For FQHC-based AEs, achieving savings through a return on investment project.

EOHHS expects to continue the same incentive fund structure for program year 5 (FY23).

Complete program documents detailing how total cost of care and the incentive program are operationalized, as well as the AE Roadmap and sustainability plan, are available on the EOHHS website:

<https://eohhs.ri.gov/initiatives/accountable-entities/resource-documents>

All Programs – Rate and Caseload Changes

- 1) Please fill out the table for the specific rate and caseload changes that impact the separate programs, as has been included in testimony in the past (“Tab 4” attached file), so that the totals can be shown in the aggregate and by program.

See testimony and Excel workbook.

- 2) Please include the hospital July 1 increase, nursing home October 1 increases, home care rate increase, and policy adjustor as well as managed care plan changes. Consistent with the interpretation of current law made in the May 2021 Caseload Estimating Conference Report, the provided estimate should not include a productivity adjustment.

FFS Service Type	SFY 22	SFY 23
Inpatient Hospital	2.4%	2.7%
Outpatient Hospital	2.4%	2.4%
Nursing Facilities	2.2%	1.9%
HCBS	0%	0%
Managed Care*	SFY 22	SFY 23
Inpatient Hospital**	2.4%	2.0%
Outpatient Hospital**	2.4%	2.4%

Nursing Facilities	2.2%	1.9%
HCBS	0%	0%

[*] Please note that the composite rate increase used for all the capitated payments was 5.0% and so EOHHS did not separately apply a price factor to the discrete components of the rates. The 5.0% rate increase therefore reflects composite changes in price, utilization, and acuity across all types of services.

However, any adjustment to the price factor that the legislature enacts can be mandated by EOHHS and passed through to the health plans. Therefore, marginal savings or costs associated with relative changes to these rate factors can be estimated by using the “Spending by Type of Service” (by product/budget line) that is included in the Excel workbook.

[**] Per RIGL 40-8-13.4 hospital rates reimbursed under managed care are adjusted each July 1st, based on the change in the Centers for Medicare and Medicaid Services national CMS Prospective Payment System (IPPS) Hospital Input Price Index, less Productivity Adjustment¹. Consistent with the interpretation of current law made in the May 2021 Caseload Estimating Conference Report, the market basket applied under Medicaid Fee For Service does not include the productivity adjustment. Additionally, please note that the “CMS Actual Regulation Outpatient Hospital PPS Market Basket” for CY 2022 has not yet been posted; this index is updated on a calendar year and will be known in the Spring prior to May CEC. Therefore, EOHHS assumed a 2.4% increase in its estimate for FY 2023, consistent with the change in the market basket in FY 2022.

Long-Term Care

- 1) Please provide fee-for-service nursing home expenses and methodology.

See testimony.


- 2) Please provide the enrollment and capitation rate information for the PACE program.

See testimony.

PACE rates are draft at this point. CMS requires PACE rates to be less than the “amount that would otherwise have been paid” (AWOP) for the individuals in the PACE program to be in compliance with the requirements at 42 CFR 460.182. This has always been a requirement, but FY 2022 is the first year in which the program that is the basis for the AWOP has changed from RHO Phase I to FFS. Although RHO I ended in 2018, the PACE methodology in the State Plan allowed for those rates to be trended forward until FY 2022. As a result of the change in the AWOP program, rates for PACE are not yet finalized for FY 2022.

- 3) Please provide an update on all current LTSS activities including most current initiatives.

See attachment two for all initiatives, except the three below.

LTSS Activity Name	Status Update
Minimum Staffing Law	On track for 10/1/21 implementation, pending SPA approval.
Category F Elimination (DHS Budget)	Delayed from 10/1/21 to 11/1/2021
No Wrong Door	Please see PowerPoint below for recent updates  NWD Update PCOC Overviewforbudget_1

- 4) Please provide details on the LTSS application backlog vs. the number of applications.

¹ <http://webserver.rilin.state.ri.us/Statutes/TITLE40/40-8/40-8-13.4.HTM>

Information on LTSS applications is available monthly on the transparency portal here: [State of Rhode Island: Transparency: UHIP \(ri.gov\)](#). As of last reporting on 9/16/2021, there were 200 total complete pending applications. 28 of them are overdue and 172 of them are not overdue.

- 5) Please provide a breakdown of type of service for home and community care expenses identified as “All Other HCBS” in the monthly Medicaid Expenditure report.

Please note that the monthly Medicaid Expenditure Reports produced by Gainwell and provided to fiscal staff by EOHHS reflect FFS claims on a paid basis. EOHHS’ testimony reflects claims on an incurred basis completed for IBNR and forecasted current and subsequent fiscal year.

The “All Other HCBS” as defined by Gainwell consists primarily of home care, shared living, and adult day. These expenditures are separated into explicit subcategories within **Home and Community Care** budget line in EOHHS’ testimony. The “All Other HCBS” reported by Gainwell also includes some expenditures for Targeted Case Management and DME for members in waiver categories; these expenditures as classified among the “Other HCBS” in EOHHS’ testimony. (Note that most Case Management and DME expenditures are reflected in the Other Services budget line.)

- 6) Please provide an explanation for the separate components of the nursing home rate increase, including the adjustment for patient share.

Nursing home per diems are comprised of the following components:

- Direct care. Reimburses for nursing salaries (RNs, LPNs, and CNAs) and fringe benefits. This component is the same for all facilities and was set at the start of the RUG-based by reviewing each facility’s costs and then setting an average for the state. Since 2013 when the average was set, this component has been adjusted by an inflationary index set by the General Assembly. The Direct Care component is adjusted by a RUG weight, to account for patient acuity. (For example, a patient on a ventilator would receive a higher rate than someone not on a ventilator). The RUG weight acts as a multiplier on the base rate. This rate is updated annually, pursuant to RIGL §40-8-19. (2)(vi), or other inflationary adjustment set by the General Assembly.
- A Provider Base Rate which is the sum of the components below
 - Other direct care which reimburses for other direct care expenses such as recreational activity expenses, medical supplies, and food. This component is the same for all facilities and was set at the start of the RUG-based by reviewing each facility’s costs and then setting an average for the state. Updated annually, pursuant to RIGL §40-8-19. (2)(vi), or other inflationary adjustment set by the General Assembly.
 - Indirect care which reimburses facilities for all other nursing facility operating expenses, like administration, housekeeping, maintenance, and utilities. This component is the same for all facilities and was set at the start of the RUG-based by reviewing each facility’s costs and then setting an average for the state. Updated annually, pursuant to RIGL §40-8-19. (2)(vi), or other inflationary adjustment set by the General Assembly.
 - Fair rental value which is facility specific and was determined as of 7/1/2012 based on a formula included in the current Principles of Reimbursement. Updated annually, pursuant to the State Plan which requires EOHHS to use the Global Insight Nursing Home Capital Cost Index.
 - A per diem tax that is facility specific and based on real estate, property taxes, and fire tax paid, and the Medicaid census days. Updated annually based on information from the BM-64 Cost Reports.

The Direct Care and Provider Base Rates are grossed up by 5.82% to make the provider’s whole after the required 5.5% nursing facility provider tax (RIGL 44-51-3)

The cost to the state is not the full per diem, as there is a patient share contribution deducted from the amount paid to the providers. In most years, EOHHS assumes that beneficiaries’ incomes are not materially changing, so patient share contributions are not changing in dollar value. However, EOHHS has recently

recognized that despite many exogenous variables, it appears patient share is actually a relatively constant percent of the full per diem (rather than a constant dollar value)

- 7) Please provide the nursing and hospice days needed for the long-term care financing adjustment (Sullivan/Perry).

See Major Developments and Nursing and Hospice Care section of testimony.

Managed Care

- 1) Please provide estimates for Managed Care, broken down by RItE Care, RItE Share and fee-for-service for FY 2022 and FY 2023.

See testimony.

- 2) Please delineate those aspects of managed care programs not covered under a payment capitation system.

All acute services are included in capitation payments, except for Transplant and Hepatitis C Stop Loss programs for Transplants, Hepatitis C, and NICU stays.

While short-term nursing services where medically necessary are a covered benefit on all products, only the CMS Demonstration (i.e., RHO Phase II) includes comprehensive coverage for long-term care services and supports. Community and residential services for Rhode Island's Medicaid-eligible I/DD population is generally paid on a fee-for-service basis (included in BHDDH budget).

The Managed Care FFS line captures costs incurred in the pre-enrollment period, FQHC wrap payment for dental services not included in the Rite Smiles contract and wrap services for Rite Share.

Eligible members may also utilize LTSS services not covered under a payment capitation system.

The table below provides a brief schedule of in-plan services. The exhibit is taken from Attachment A, "Schedule of In-Plan Benefits" in the MCO Medicaid Managed Care Services contracts.

FIGURE 3: MANAGED CARE BENEFIT PACKAGE

Inpatient and Outpatient Hospital	School-Based Clinic Services
Therapies	Services of Other Practitioners
Physician Services	Court Ordered Mental Health and Substance Use Services
Family Planning Services	Court Ordered Treatment for Children
Prescription and Non-Prescription Drugs	Podiatry Services
Laboratory, Radiology, and Diagnostic Services	Optometry Services
Mental Health and Substance Use Inpatient and Outpatient Services	Oral Health
Home Health and Home Care Services	Hospice Services
Preventive Services	Durable Medical Equipment
EPSDT Services	Case Management
Emergency Room Services	Transplant Services
Emergency Transportation	Rehabilitation services
Nursing Home and Skilled Nursing Facility Care	Other Miscellaneous Services

Note: Hepatitis C drugs and COVID-19 vaccine administration professional charges are covered under a non-risk payment from EOHHS to the MCOs.

Covered services are consistent with the SFY 2020 benefit package. Detailed benefit coverage information for all benefits listed in this figure can be found within Attachment A, "Schedule of In-Plan Benefits" in the MCO Medicaid Managed Care Services contracts. In-lieu-of services may also be provided with written approval from EOHHS.

- 3) Please provide the monthly capitation rate(s) for RItE Care.
- a. When were the FY 2022 capitation rates finalized with the managed care plans? What were those final rates?
- FY 2022 rates were finalized August 12, 2021. See testimony for an exhibit with those rates.
- b. If different from the rate assumed in the enacted budget, please document the change according to contributing factors such as medical expense trends, risk/claims adjustment assumptions, and

administrative costs. Also, where the testimony cites a percent-based caseload or cost inflator, please ensure that the specific cost impacts are also provided.

On a composite basis, managed care rates (using actual enrollment from FY 2021 and forecasted enrollment for FY 2022) increased by 3.7% year/year. The May adopted estimate for Rite Care assumed a composite rate increase of 3.5%, prior to consideration of the additional funds for Hep C and Transplant Stop Loss moved in-plan starting in FY 2022.

- 4) Please provide the CHIP funding included in the FY 2021 preliminary closing and the projections for FY 2022 and FY 2023, as well as a breakdown of any state-only expenditures and CNOM-funded expenditures in the estimates. If the estimate has changed since the FY 2022 Enacted Budget, please provide an explanation for the change.

See testimony.

CHIP claiming is driven by the enrolled population eligible for CHIP. Because our enrolled population is estimated to be greater in FY 2021, is forecasted to increase in the current year. In FY 2023, EOHHS anticipated CHIP claiming to decline in proportion to the decline in enrollment forecasted for that period

Rhody Health Partners

- 1) Please provide estimates for Rhody Health Partners for FY 2022 and FY 2023. Please delineate those aspects of managed care programs not covered under a payment capitation system.

See above response under **Managed Care** questions. RHP members who have a long-term care authorization are eligible for LTSS services not covered under a payment capitation system. **These expenditures would appear in Home and Community Care or Nursing and Hospice Care budget lines.**

- a. Please provide the monthly capitated payment for the different groups enrolled in Rhody Health Partners.

See testimony

- 2) When were the FY 2022 capitation rates finalized with the managed care plans?

FY 2022 rates were finalized August 12, 2021. See testimony for an exhibit with those rates.

- b. If final rates are different from the prior capitation rate adopted in November, please document the change according to contributing factors such as medical expense trends, risk/claims adjustment assumptions, and administrative costs.

On a composite basis, the Rhody Health Partners rates (using actual enrollment from FY 2021 and forecasted enrollment for FY 2022) increased by 7.3% year/year. The May adopted estimate for Rhody Health Partners assumed a composite rate increase of 3.5%, prior to consideration of the additional funds for Hepatitis C Stop Loss moved in-plan starting in FY 2022.

Hospitals

- 1) Please provide separate inpatient and outpatient estimates for hospital services in FY 2022 and FY 2023.

See Hospital – Regular of the testimony.

- 2) For the DSH payment, please provide an update on the recent federal update that allows the enhanced FMAP rate to be applied to this payment for FY 2023.

See Major Developments and Hospital – DSH section of testimony.

Pharmacy

- 1) Please provide separate estimates of pharmacy expenditures and rebates for FY 2022 and FY 2023.

See Major Developments and Pharmacy sections of testimony.

Other Medical Services

- 1) Please provide an updated estimate of receipts for the Children's Health Account and expenditures for all Other Medical Services by service.

See **Other Services** section of testimony.

- 2) Please provide the methodology that calculates the projected Medicare Part A and B premium costs in FY 2022 and FY 2023.

See **Other Services** section of testimony.

- 3) What are the state-only costs in FY 2022 and FY 2023?

Although not budgeted as state-only, the amount currently budget within **Other Services** for the \$0.5 million audit finding related to the Ryan White program and shifting claims to Medicaid could become state-only depending on the timing of claims and HRSA determination.

Medicaid Expansion

- 1) Please provide updated caseload and expenditure estimates for FY 2022 and FY 2023 for the ACA-based Medicaid expansion population.

See **Medicaid Expansion** section of testimony.

- 2) When were the FY 2022 capitation rates finalized with the managed care plans?

FY 2022 rates were finalized August 12, 2021. See testimony for an exhibit with those rates.

- 3) If final capitation rates are different from the prior capitation rate adopted in the FY 2022 Enacted Budget, please document the change according to contributing factors such as medical expense trends, risk/claims adjustment assumptions, and administrative costs.

On a composite basis, the Expansion rates (using actual enrollment from FY 2021 and forecasted enrollment for FY 2022) increased by 5.9% year/year. The May adopted estimate for Rhody Health Partners assumed a composite rate increase of 3.5%, prior to consideration of the additional funds for Hep C and Transplant Stop Loss moved in-plan starting in FY 2022.

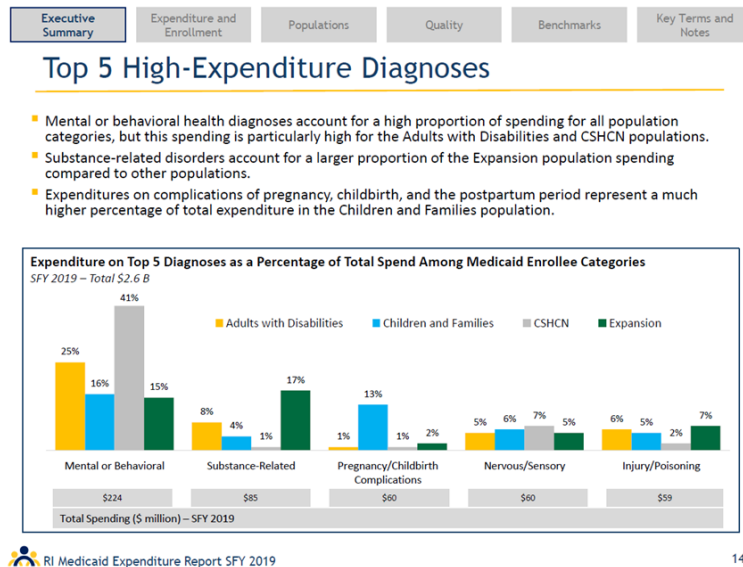
Behavioral Health

- 1) Please provide an estimate for FY 2022 and FY 2023 of Medicaid expenditures for behavioral health services, including overall BH spending over that time (e.g., Medicaid spend on primary BH diagnoses).

In FY 2019, Medicaid spent \$224 million on claims where a behavioral health condition was the primary diagnosis on the claim and \$85 million where substance use disorder was the primary diagnosis. Condition assignment to a behavioral health or substance use disorder classification was done using the clinical classification software (CCS) from the federal Agency for Healthcare Research and Quality.

Please note that these figures do not include behavioral health related spending for specific diagnoses related to developmental disabilities that elsewhere may be appropriately classified as behavioral health or mental health. Nor do these expenditures include spending on BH-related prescriptions for pharmaceuticals.

Additionally, this exhibit is based on claims (both Managed Care and Fee For Service) present in the MMIS and is not adjusted to reflect missing managed care encounter data.



- a. What are the projected expenses for the MHPRR services for FY 2022 and FY 2023? In what program or programs do these expenses occur? How many individuals are enrolled in the program for FY 2022 and projected for FY 2023?

Mental Health Psychiatric Rehabilitative Residential (group home and supportive housing) or MHPRR services provide 24-hour staff having persistent and severe impairments resulting from extreme persistent disabilities. This benefit is provided in FFS and in Managed Care. Both delivery systems use procedure code H0019 with modifiers to bill for this service. The current reimbursement is as follows:

Current FFS Rates for H0019 by modifier:

- U1- \$85- supervised apartment
- U3- \$125- apartment, moderate acuity
- U4- \$125- group home, moderate acuity
- U5- \$175, high intensity

MCO rates appear comparable.

Total Medicaid spending is around \$16.5 million per annum. Nearly all the FFS spending is included in the **Other Services** budget line. Presented below is the total spending and average cost per unit, per user (per month), and monthly utilization, for FY 2020 and FY 2021.

Agency		
Delivery System		
	2020	2021
Average Monthly Users		
H0019U1	32	29
H0019U3	72	87
H0019U4	275	295
H0019U5	19	23
Paid Amount		
H0019U1	\$841,389	\$780,325
H0019U3	\$3,023,453	\$3,116,983
H0019U4	\$11,247,290	\$11,337,939
H0019U5	\$983,456	\$1,299,244
Unit Cost		
H0019U1	\$87	\$92
H0019U3	\$125	\$125
H0019U4	\$126	\$127
H0019U5	\$193	\$192
Total Average Monthly Users	398	434
Total Paid Amount	\$16,095,588	\$16,534,491
Total Unit Cost	\$126	\$128
% in Managed Care	59%	58%

- b. How many individuals receiving specialized, intensive services, such as ACT, are enrolled as “medically needy”?

See response below.

- c. What costs are projected for the opioid treatment health home program in FY 2022 and FY 2023? How many individuals receiving the service are part of the medically needy coverage group?

EOHHS has two health home programs that provide intensive care management services for the behavioral health needs of its Medicaid members. These include the Integrated Health Home (IHH) and Opioid Treatment Program (OTP) and Center for Excellence (COE). Additionally, members in Medicaid’s Assertive Community Treatment (ACT) program are provided with IHH services as part of the bundled payment to the CMHO serving these members. These benefits are provided in FFS and in each of the managed care products. Most of the FFS spending is included in the Other Services budget line.

Approximately 11,500 Medicaid members are presently authorized across these four programs:

	<i>Regular</i>	<i>SSI-like</i>	<i>Medically Needy</i>	<i>Expansion</i>	<i>Total</i>
<i>Integrated Health Home (IHH)</i>	4,652	959	199	1,309	7,119
<i>Assertive Community Treatment (ACT)</i>	921	203	76	192	1,392
<i>Opioid Treatment Program (OTP)</i>	1,176	140	11	1,637	2,964
<i>Center of Excellence (COE)</i>	50	7		82	139
<i>Total Health Home Authorizations</i>	6,799	1,309	286	3,220	11,614

Approximately 90% of IHH/ACT authorized users and 75% of OTP authorized users have associated claims activity in any given month. The monthly health home cost for IHH and ACT is \$420.55 per month. (Note that the monthly cost for ACT is \$1,267, but that includes non-health home behavioral health services as well). The health home cost for OTP is \$220 per month.

- 2) Please provide enrollment and costs expected to be incurred in FY 2022 and FY 2023, for the following programs. Please indicate the costs to programs individually.
- a. IHH, ACT, OTP Programs.

IHH (H0037), ACT (H0040) and OTP (H0037 at Provider Type '060') total about \$4.29 million per month, with approximately \$1.25 million per month in FFS.

b. Behavioral Health Link Program

The BH Link (H2011) for crisis intervention services costs \$10,000 per month including \$5,000 per month in FFS.

c. Centers of Excellence.

Medicaid spends approximately \$25,000 per month on Centers of Excellence (H0022 and H0025) including \$15,000 per month in FFS. This amount does not include the J-Code billings for Buprenorphine.

d. Peer Supports Programs

Medicaid spends anticipates spending approx. \$33,000 per month on its peer supports program (H0038), including \$15,000 per month in FFS.

e. Housing Stabilization Program

EOHHS' estimate includes \$1.9 million in FY 2022 and \$2.6 million in FY 2023 for Home Stabilization (H0044). These estimates reflect the rate increase assumed in FY 2022 Enacted. This is an increase from the \$285,000 budgeted in FY 2021 for this program and \$20,563 incurred and paid between January and June 2021 when the service was first offered to Medicaid members. At present this is assumed to be a FFS only expense.

Summary of spending for FY 2021 by Delivery System is included below:

	FFS	Managed Care	Total
<i>Integrated Health Home (H0037)</i>	\$8,468,260	\$23,773,103	\$32,241,363
<i>Assertive Community Treatment (H0040)</i>	\$5,891,709	\$12,481,452	\$18,373,162
<i>Opioid Treatment Program (H0037)</i>	\$477,462	\$394,155	\$871,617
<i>Center of Excellence (H0022/H0025)</i>	\$180,725	\$122,385	\$303,110
<i>BH Link (H2011)</i>	\$57,655	\$53,598	\$111,252
<i>Peer Support Program (H0038)</i>	\$188,227	\$204,690	\$392,917
<i>Home Stabilization (H0044)</i>	\$20,563		\$20,563
Total	\$15,284,602	\$37,029,382	\$52,313,984